DSS-CP-506-08/91 PLEASE RETURN TO:

HEALTH REPORT

Part A: Physical exam - This section is to be completed by a physician or physician's assistant.

Note to Physician:

_____ is applying to be a _____
(Name of Applicant)

Your opinion as to this person's freedom from physical or mental illness which might be detrimental to the care of children is a governing factor in his/her approval. Be assured that this information will be used for licensing/ approval purposes only. A physical exam given to the applicant within one year prior to this application is acceptable for purposes of meeting this requirement.

Date when the applicant was seen: _____ Is the applicant under treatment for chronic illness?

____ Yes ____No If so, what is the diagnosis? _____

What medications are prescribed? _____

General condition of health: _____

Are there any emotional, mental or physical factors which would interfere with this individuals ability to care for children in her/his home?_____

_____

_____

This section is only to be completed if the applicant is a reactor to T.B. tests and has not completed a course of INH therapy.

Please verify this individual's freedom from infection if (s)he is a reactor to T.B. tests.

_____

_____

Signed: _____ Date: _____
Signature of MD or PA

Please see the back of this form for T.B. tests and immunizations report.

Part B: T.B. Tests - This section is to be completed by a nurse, physician's assistant or physician.

Note to medical personnel:
Licensing standards require that an applicant and each household member who is over the age of 1 year must have a mantoux tuberculin test. Individuals who react to T.B. tests and have completed a course of INH therapy are exempt from testing. Individuals who react to T.B. tests but have not completed a course of INH therapy are to be referred to a physician for verification of freedom from disease. Please record the T.B. test results below.

NAME	DATE OF TEST	RESULT OF TEST	DATE COMPLETED COURSE IN INH	REACTS TO TESTING NO INH. -- REFERRED TO M.D.

Signed: _____ Date: _____
Signature of Nurse, PA or MD

Part C: Immunization Record - This section may be completed by the applicant and is to document the immunizations of his/her own children who are under the age of 18. Please indicate the dates of the immunizations in the appropriate box. S.D. Law allows for medical and religious exemptions to immunization if the immunization would endanger the health of the child or if a parent's religion prohibits immunization. Please inform the licensing worker if you wish to claim an exemption.

NAME OF CHILD	POLIO	RUBELLA	MEASLES	MUMPS	DPT
Name: **DOB:**					
Name: **DOB:**					
Name: **DOB:**					
Name: **DOB:**					
Name: **DOB:**					
Name: **DOB:**					

I certify that this is the correct record of my children's immunizations.

Signed: _____ Date: _____
Signature of Applicant